Pennsylvania Individual Health Insurance

Localized Rating Area Analyses — All Nine Areas

June 2026 · Part of the Pennsylvania Meta-Analysis Series

METHODOLOGY NOTE: This document is a secondary evidence synthesis. All empirical claims are confidence-rated. All statutory citations are to primary codified authorities. No finding should be applied in any regulatory or legal proceeding without first retrieving the primary source identified in the Source Validation Appendix of the accompanying Meta-Analysis.

RA	Region	Score	Archetype	Defining Characteristic	Section
8	Philadelphia Metro	**6**	**A**	14 carriers; arbitrage market; −22,000	p. 3
3	Northeast PA (Scranton)	**7**	**A**	Partners −10.12%; premium arbitrage anchor	p. 5
4	Pittsburgh Metro	**10**	**B**	−18,500 enrolled; youth exit 2.1× avg	p. 7
7	Capital Region (Harrisburg)	**10**	**B**	Silver Generation: York County $7k→$35k	p. 9
5	West Central PA	**13 B***	**B* ← Fragile**	Morbidity death spiral; Bronze peak	p. 11
6	Lehigh Valley (Allentown)	**13 B***	**B* ← Fragile**	Mental Health Desert; 14.9% appt rate	p. 13
1	Northwest PA (Erie Hub)	**14**	**C**	Duopoly; telehealth substitution erosion	p. 15
9	South Central Rural	**16**	**C**	Juniata 485% surge; Act 54 = sole remedy	p. 17
2	North Central Rural (Elk/Cameron/Potter)	**19**	**C ← MOST SEVERE**	Near-monopoly; 87% directory inaccuracy	p. 19

Note. A = Competitive Shock Absorption (0–8). B = Vertically Integrated Stability (9–13). B = Upper boundary of B; one actuarial cycle from C. C = Rural Structural Failure (14–20). Scores from Meta-Analysis Table 4.*

RATING AREA 8 · PHILADELPHIA METROPOLITAN

Counties: Bucks, Chester, Delaware, Montgomery, Philadelphia | Score: 6 | **Archetype A — Competitive Shock Absorption**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
0	**2**	**1**	**2**	**1**	**6**

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 1

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
IBX / Keystone Health Plan East	23.5%	**22.04%**	PPO → Proactive HMO transition; Tier 1 Penn Medicine access required; all GLP-1s require PA; specialty tier cost-sharing increased
QCC Insurance Company	8.0–10.0%	**15.18%**	Regional PPO alternative; lowest increase in Philadelphia market; maintained network breadth
Oscar Health Plan of PA	21.6%	**23.12%**	Digital-first EPO; no PCP referral; SE/NE PA footprint expansion; mandatory GLP-1 PA
Ambetter (Centene)	30.1%	**37.85%**	Restrictive HMO statewide; aggressive Bronze pricing; near-universal GLP-1 PA; worsening morbidity
Health Partners Plans	7.3%	**16.67%**	Integrated; virtual-first network option; disease burden adjustment
IBX / QCC (combined)	14.5%	**13.8%**	Maintained breadth; increased specialty tier cost-sharing

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 2

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Philadelphia County	142,000	120,000	~22,000	**15.5% — highest absolute loss in Commonwealth**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

Market Structure: Why High Volatility and High Resilience Coexist

Rating Area 8 experienced the highest absolute enrollment loss in the Commonwealth — approximately 22,000 individuals (Moderate confidence — Pennie modeled data, as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026) — yet its 15.5% proportional decline is lower than nearly every other rating area. The resolution of this apparent paradox is carrier density: 14 competing insurers mean that premium shock translates to plan migration rather than disenrollment for the consumers who can execute the switch. When Ambetter's 37.85% increase became untenable, QCC's 15.18% floor provided a real migration target. This competitive dynamic is the structural mechanism that suppresses proportional losses in Archetype A markets even as absolute losses remain large due to population scale.

The IBX transition from broad PPO to restrictive Proactive HMO is the dominant structural risk for existing enrollees. Tier 1 Penn Medicine access is required for maximum plan value; a specialist inadvertently assigned to Tier 2 generates higher cost-sharing without any OON billing — the provider is technically in-network, but the financial exposure is materially higher. This is not a network adequacy violation under 45 C.F.R. § 156.230(a)(2) because the provider is in-network; it is a plan design feature that requires active verification before every specialist encounter.

Dominant Harm Vector: OON Ancillary Billing at In-Network Facilities

The source compilations identify Rating Area 8 as the epicenter of balance billing disputes due to OON pathology, radiology, and anesthesiology codes appended to in-network facility claims (Pennsylvania Consumer Advocacy and Health Billing Protections [Internal project report], 2026). The No Surprises Act, Pub. L. No. 116-260, Div. BB, Title I (2021), categorically protects these ancillary services from balance billing when the patient had no opportunity to choose the provider. The recommended EOB surveillance protocol for RA8 consumers: scan every Explanation of Benefits for OON ancillary codes immediately upon receipt, before any collection activity begins.

The preventive-to-diagnostic billing conversion is the second dominant harm vector. When a chronic condition is discussed during a covered wellness visit and the provider recodes the

encounter as diagnostic, the entire visit becomes subject to the deductible. Gold-plan enrollees in RA8 face deductibles of $500–$1,000 for this recode; Bronze-plan enrollees face deductibles exceeding $7,500. The point-of-service intervention — asking the provider before any chronic condition is mentioned whether the visit will be billed as preventive or diagnostic — is the primary consumer defense.

Statutory Enforcement Toolkit — This Rating Area

No Surprises Act, Pub. L. No. 116-260, Div. BB, Title I (2021): OON ancillary services at in-network facilities are categorically protected. Pathology, radiology, anesthesiology codes are the dominant dispute category in RA8.

Act 252 of 2023 (P.L. 2023, No. 252): Network-status disclosure before non-emergency care. Any balance bill without prior written/electronic disclosure is presumptively illegal and independently actionable.

28 Pa. Code § 9.725 (Hold-Harmless): Enrollee liability capped at in-network cost-sharing when network adequacy fails or contracts are in dispute.

Act 146 External Review: 45-day max; 42% reported carrier denial reversal rate [Moderate confidence]. Primary GLP-1 PA appeal pathway.

42 U.S.C. § 300gg-115 (Directory Reliance): OON care from inaccurate directory: carrier must process at in-network rates. NOT IDR (45 C.F.R. § 149.510) — IDR is provider-vs-plan arbitration only; not a consumer remedy.

RATING AREA 3 · NORTHEASTERN PENNSYLVANIA

Counties: Lackawanna, Luzerne, Monroe, Carbon, and surrounding counties | Score: 7 |
Archetype A — Competitive Shock Absorption / Arbitrage Anchor

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
1	3	2	3	2	7

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 3

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Partners Insurance / Jefferson Health Plans	-10.1%	**-10.12%**	Streamlined EPO; clinical integration post-Jefferson rebrand; step therapy GLP-1; ONLY approved rate decrease in PA 2026
Oscar Health Plan of PA	21.6%	**23.12%**	Digital-first EPO; NE PA footprint expansion; mandatory GLP-1 PA; risk pool instability adjustment
Highmark, Inc.	17.2%	**17.75%**	Network restructuring; narrow EPO; HSA-compatible; aggressive PA audits
Ambetter (Centene)	30.1%	**37.85%**	Statewide; restrictive HMO; near-universal GLP-1 PA; aggressive Bronze

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 4

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Lackawanna/Luzerne (Scranton Hub)	~38,000	~32,200	~5,800	**15.3% — highest modeled subsidy shock outside Pittsburgh**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

The Premium Arbitrage Mandate: Empirical Proof of Concept

Rating Area 3 is the definitive empirical proof that the subsidy cliff's damage is not purely a function of federal policy — it is also a function of carrier diversity. Partners Insurance Company's approved 10.12% rate decrease (High confidence — PID rate filings) creates a genuine pricing floor that makes plan migration the mathematically rational response to premium shock for price-sensitive consumers. The 23.12%-versus-negative-10.12% spread between Oscar and Partners operating in the same geography is the quantitative expression of what competitive markets can do that monopoly markets cannot: the consumer who finds Oscar unaffordable has Partners as an actionable alternative. In Juniata County (Rating Area 9), the same consumer has no such option.

Partners achieved its rate reduction through clinical integration efficiencies following rebranding as Jefferson Health Plans and adoption of a streamlined EPO design (Pennsylvania Insurance Department, 2025, as cited in The Pennsylvania EPO Shift [Internal project report], 2026). This is clinically grounded cost reduction rather than competitive positioning alone — which matters for the 2027 sustainability outlook. A carrier that reduced rates through genuine efficiency gains is more likely to sustain that trajectory than one that reduced rates purely to capture market share.

Upcoding and the CPT 72148 Forensic Benchmark

Rating Area 3 hosts the highest documented concentration of chronic condition management activity associated with provider upcoding. The forensic benchmark from the source compilations: Lumbar Spine MRI (CPT 72148) billed at $1,500 against FMV of approximately $443 — a 238.3% variance triggering a Critical Overcharge flag (***Moderate confidence — case study; verify against billing records before regulatory use***). FMV benchmarked at 1.65× 2026 Medicare Physician Fee Schedule, Locality 24 (PA-East); initial negotiation anchor at 1.40× MPFS (*Upcoding and Pennsylvania Medical Premium Inflation 2026* [Internal project report], 2026). The upcoding mechanism: incentivized by MPFS adjustments, providers facing contracting insured bases shift Level 3 encounters to Level 5, unbundle bundled procedures, and recode preventive visits as diagnostic when chronic conditions are discussed.

Statutory Enforcement Toolkit — This Rating Area
Act 252 of 2023 (P.L. 2023, No. 252): Point-of-service disclosure mandate. OON status must be disclosed before non-emergency care; failure bars balance billing independently of NSA.

No Surprises Act / 45 C.F.R. § 149.410: NSA billing protections for ancillary services at in-network facilities. Combined with Act 252, two-layer shield against most RA3 balance billing.

Act 2339 / HB 2339 (Hospital Price Transparency): Machine-readable files of standard charges. Anchor billed amounts against hospital's actual median allowed amount to establish forensic overcharging evidence in upcoding disputes.

Act 146 External Review: GLP-1 PA denials: 42% reported reversal rate [Moderate confidence]. File within 180 days of denial.

Partners/Jefferson Arbitrage (Non-Statutory): Systematic annual migration to Partners/Jefferson as first-line cost mitigation. The only market in the Commonwealth where a carrier's rate decrease creates an actionable consumer escape hatch from double-digit increases.

RATING AREA 4 · PITTSBURGH METROPOLITAN

Counties: Allegheny, Beaver, Butler, Lawrence, Washington, and surrounding counties | Score: 10 | **Archetype B — Vertically Integrated Stability with Morbidity Risk**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
1	**3**	**2**	**2**	**2**	**10**

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 5

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
UPMC Health Options, Inc.	11.7–16.3%	**20.18%**	UPMC integrated; UPMC First Care introduced; 6 free BH visits; mandatory GLP-1 PA; value-based transition
UPMC Health Plan, Inc.	16.3%	**24.78%**	Pittsburgh/Northwest; strict GLP-1 PA; worsening morbidity; largest upward revision in Commonwealth
UnitedHealthcare	Not in source	**12.6%**	Value Leader positioning; HMO/EPO; capturing market share; lowest rate in RA4
Highmark, Inc.	17.2%	**17.75%**	Together Blue (AHN + St. Luke's); Sword virtual care; CopayGo tiered

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 6

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Allegheny County (Pittsburgh Hub)	~118,000	~99,500	~18,500	**15.7% — second highest absolute loss in Commonwealth**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

Adverse Selection Dynamics: The Death Spiral in Early Stage

Allegheny County's 15.7% decline was characterized by young adult exit rates reportedly reaching 2.1 times the statewide average (***Moderate confidence — modeled estimate; verify against Pennie records***). This is the statistical signature of adverse selection in progress: healthy, price-sensitive young adults exit first in response to premium increases, leaving a sicker remaining pool whose higher average claims cost necessitates further rate increases. UPMC Health Plan's upward revision from a proposed 16.3% to an approved 24.78% — the largest such revision in the Commonwealth — is the regulatory acknowledgment that the carrier's own models underestimated how quickly its risk pool was deteriorating (Pennsylvania Insurance Department, 2025, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). This dynamic is currently more acute in Rating Area 5 (where it has produced an extreme morbidity classification) but is observable in Rating Area 4 as a leading indicator.

UnitedHealthcare's 12.6% approved increase is the partial arbitrage anchor in Rating Area 4, filling the competitive role that Partners plays in Rating Area 3. The critical difference is structural: Partners' reduction was achieved through clinical integration savings that are sustainable. UHC's lower rate reflects competitive positioning that is sensitive to risk pool dynamics — if RA4's morbidity deterioration accelerates, UHC faces the same adverse selection pressures as UPMC and Highmark, with fewer integrated clinical assets to manage them. Rating Area 4's Archetype B classification is therefore contingent on UHC's continued competitive presence providing a floor below the duopoly's pricing.

Medicare Advantage as Partial Stabilizer

Rating Area 4 possesses a stabilization mechanism absent from all Archetype C markets: Medicare Advantage plans, particularly UPMC for Life, serve as a migration destination for eligible 65+ residents who find Pennie premiums prohibitive (*Pennsylvania Medicare Trends and Pharmaceutical Policy 2026* [Internal project report], 2026). This mechanism does not benefit the 55–64 Silver Generation cohort facing the most acute premium shock under the 3:1 age-rating multiplier at 42 U.S.C. § 300gg(a)(1)(A)(iii). For that cohort in RA4 — too young for Medicare, too wealthy for subsidy assistance above 400% FPL — no equivalent structural buffer exists.

Statutory Enforcement Toolkit — This Rating Area

MHPAEA, 29 U.S.C. § 1185a / 29 C.F.R. § 2590.712: UPMC's 6 free BH visits requires NQTL analysis: does this limitation apply more stringently to BH than analogous medical benefits? If BH specialist access is materially more restricted than medical specialist access, file NQTL complaint with PID.

Act 146 External Review: GLP-1 PA denials across all three UPMC entities. Document BMI, step-therapy failure, and lifestyle program participation before filing; 42% reported reversal rate [Moderate confidence].

42 U.S.C. § 300gg-115 (Directory Reliance): OON care from inaccurate directory: in-network rate processing required. Not IDR (45 C.F.R. § 149.510) — IDR is provider-vs-plan only.

45 C.F.R. § 156.230(a)(2): 30-mile/30-minute adequacy standard. Document specialist access failures as foundation for OON exception request under Act 146.

RATING AREA 7 · CAPITAL REGION

Counties: Dauphin, Cumberland, Perry, York, Adams, Franklin, and surrounding counties | Score: 10 | **Archetype B — Vertically Integrated Stability with Morbidity Risk**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
2	2	2	2	2	10

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 7

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Capital Advantage Assurance	26.0%	**24.56%**	RA6/7/9; LVHN + St. Luke's access; Silver tier consolidated; deductible caps $1,500 outpatient; hospital consolidation adjustment
Highmark, Inc.	17.2%	**17.75%**	Western/Central PA; rural restructuring; HSA-compatible Bronze/catastrophic; CopayGo tiered
Ambetter (Centene)	30.1%	**37.85%**	Statewide; most restrictive HMO; near-universal GLP-1 PA

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 8

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Dauphin County (Harrisburg Hub)	~62,000	~53,000	~9,000	**14.5%**
York County (illustrative)	—	—	—	**169% net premium increase for subsidy-loss cohort [Moderate confidence — modeled]**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

The Silver Generation: Anatomy of the 55–64 Cohort Crisis

York County is the primary Silver Generation case study in this rating area. A 60-year-old married couple earning $82,000 reportedly saw annual premiums surge from $7,032 to $35,712 (***Moderate confidence — illustrative case study; not a market average; verify against carrier rate schedules***). This reflects two statutory mechanisms operating simultaneously: the 3:1 age-rating multiplier under 42 U.S.C. § 300gg(a)(1)(A)(iii), and the complete loss of federal subsidy eligibility above 400% FPL following EPTC expiration (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026). At $82,000 combined income, this couple sits precisely at the 400% FPL threshold — one dollar above it eliminates all federal assistance.

The Silver Generation's crisis has a clinical dimension distinct from general premium unaffordability. This cohort has higher chronic condition prevalence than younger enrollees. When premium shock forces a 60-year-old from a Silver plan with a $1,500 deductible to a Bronze plan with a $7,500 deductible, the statistical expectation is not that they will avoid using their coverage — it is that they will defer care until conditions escalate, producing higher-acuity emergency presentations that generate larger uncollectible balances. This is the population-level mechanism connecting the Bronze Migration in Rating Area 7 to the rural hospital infrastructure stress documented at Low-to-Moderate confidence in Rating Area 5.

Capital Advantage's Deductible Cap as a Partial Offset

Capital Advantage's decision to cap medical and pharmacy deductibles at $1,500 for outpatient services in its Silver tier (Pennsylvania Insurance Department, 2025, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026) is consistent with Pennsylvania's SB 1071 $1,500 pharmacy deductible cap for QHPs — confirming statutory compliance in the implemented product. The limitation: Capital Advantage's 24.56% gross premium increase, compounded by EPTC expiration, may price out the 55–64 middle-income households who would most benefit from the deductible protection.

Statutory Enforcement Toolkit — This Rating Area

SB 1071 (2024 Coinsurance Caps): Caps coinsurance at ≤20% for certain outpatient surgical services after deductible; $1,500 max pharmacy deductible for QHPs. Verify carrier compliance before paying higher cost-sharing.

42 U.S.C. § 18071 (Cost-Sharing Reductions): CSRs available only on Silver plans. Evaluate Silver + CSR vs. Bronze total cost of care before plan migration. At 200–250% FPL, Silver with CSR often has lower total cost than Bronze despite higher premium.

Act 146 External Review: GLP-1 PA denials; 42% reported reversal rate [Moderate confidence]. Build BMI, comorbidity, and step-therapy documentation before filing.

Act 252 of 2023: Point-of-service disclosure. Capital Advantage's broad system access does not eliminate OON ancillary exposure.

RATING AREA 5 · WEST CENTRAL PENNSYLVANIA

Counties: Armstrong, Indiana, Clarion, Jefferson, Forest, and surrounding counties | Score: 13 B* | **Archetype B* — Upper Boundary; Morbidity Death Spiral**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
2	3	2	3	3	13

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 9

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
UPMC Health Plan, Inc.	16.3%	**24.78%**	Largest upward revision in Commonwealth (16.3%→24.78%); sicker-than-expected risk pool; strict GLP-1 PA; value-based pivot accelerated
Highmark Coverage Advantage	17.0%	**14.48%**	RA1+4 coverage; stable local network; formulary restructured for strict GLP-1 PA

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 10

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
West Central (RA5 zone)	—	—	—	**Zone of extreme morbidity volatility; Bronze Migration most severe in Commonwealth [Moderate confidence — modeled]**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

The Morbidity Death Spiral: Mechanism and Regulatory Evidence

Rating Area 5 is the 2026 market's most acute demonstration of adverse selection in operational form. UPMC Health Plan's approved rate of 24.78% — revised upward from a proposed 16.3%

after regulators identified a sicker-than-expected risk pool — represents the largest such upward revision in the Commonwealth (Pennsylvania Insurance Department, 2025, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). The sequence matters analytically: the carrier did not project 24.78%. The regulator compelled it. The gap between proposed and approved is the actuarial signal of a risk pool deteriorating faster than carrier models predicted — the defining financial signature of a death spiral in progress rather than a stable high-cost market experiencing normal actuarial pressure.

The source compilations classify Rating Area 5 as a zone of extreme morbidity volatility with a massive observed transition toward Bronze-tier plans among middle-income earners in the 250%–400% FPL band (***Moderate confidence — modeled data***). Bronze Migration in RA5 is described as proportionally the most severe in the Commonwealth. The actuarial consequence is self-reinforcing: healthy enrollees exit to Bronze or disenroll entirely, leaving a sicker remaining pool whose higher claims cost drives the next rate increase above what a stable pool would require, which drives further healthy-member exit.

Rural Hospital Infrastructure Risk

Three rural Pennsylvania hospital labor and delivery unit closures in early 2026 are attributed in the source compilations to payer-mix deterioration from Bronze-loading in markets of this type (***Low-to-Moderate confidence — hospital identities not identified in compilations; attribution is analytical inference; verify against Pennsylvania Hospital Association records at phalink.org***). The mechanism is analytically defensible: rural hospitals absorb higher uncompensated care as Bronze deductibles prevent patients from satisfying financial obligations, and high-deductible plans deter routine utilization until conditions escalate to emergency presentations that generate larger uncollectible balances. This is the direct financial pathway from the Bronze Migration to rural hospital closure risk, even where specific institutional evidence requires independent verification.

Statutory Enforcement Toolkit — This Rating Area

Act 146 External Review: GLP-1 PA denials: UPMC's strict criteria require documented BMI threshold, step-therapy failure, and lifestyle program participation. External review is primary appeal pathway. Build clinical documentation before the initial PA request.

MHPAEA NQTL, 29 U.S.C. § 1185a: If BH network produces appointment waits exceeding the 10-business-day standard under 45 C.F.R. § 156.230(a)(2) while medical specialist access is not equivalently restricted: impermissible NQTL — file with PID and federal DOL/CMS for self-funded plans.

42 U.S.C. § 300gg-115 (Directory Reliance): Ghost network risk: maintain records of directory entries relied on before OON care. In-network rate processing required where directory reliance is demonstrable. NOT IDR.
1332 Reinsurance Waiver Expansion (Policy): The structural intervention most likely to break the morbidity feedback loop. Projected additional 5% gross reduction [Low-Mod. confidence] from proposed waiver expansion.

RATING AREA 6 · LEHIGH VALLEY

Counties: Lehigh, Northampton, Carbon, Monroe, and surrounding counties | Score: 13 B* | **Archetype B* — Upper Boundary; Mental Health Desert**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
2	3	3	2	3	13

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 11

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Capital Advantage Assurance	26.0%	**24.56%**	RA6/7/9; LVHN + St. Luke's; Silver tier consolidated; $1,500 deductible cap outpatient
Keystone Health Plan Central (IBX)	27.9%	**22.4%**	High-utilization HMO; WellSpan + Penn State Health reclassified to Group 2 higher-cost; network tightening
Highmark, Inc.	17.2%	**17.75%**	my Direct Blue Lehigh Valley EPO; tiered partnerships Penn State Health + WellSpan
Oscar Health Plan of PA	21.6%	**23.12%**	Digital-first EPO; multi-region including RA6; no PCP referral required

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 12

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Lehigh/Northampton (Allentown Hub)	—	—	—	**~15.2% enrollment decline; Mental Health Desert classification [Moderate confidence]**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

Mental Health Desert: Quantitative Definition and Evidentiary Status

The Mental Health Desert classification applied to Lehigh County in the source compilations is defined by three metrics from the Texas A&M University secret shopper study commissioned by PID (primary study not directly reviewed; all three figures are ***Moderate confidence*** — verify against primary study before regulatory submission): (1) Successful Appointment Rate of 14.9% — one in seven listed mental health providers actually available to provide care; (2) average behavioral health wait times of 33.2 days against the federalized 10-business-day maximum under 45 C.F.R. § 156.230; (3) pediatric mental health listing inaccuracy rate of 62.8%. The 33.2-day wait represents a 3.3× violation of the statutory maximum — not a marginal shortfall but a documented quantitative failure (Texas A&M University, as cited in *The Mirage of Care* [Internal project report], 2026).

Under the NQTL framework established in the meta-analysis: if no analogous access failure exists for medical specialists — if orthopedic surgery networks, for example, produce successful appointment rates materially higher than 14.9% — then the behavioral health network design constitutes a facially impermissible NQTL. Carriers are required under MHPAEA implementing regulations at 29 C.F.R. § 2590.712 to demonstrate that network adequacy standards are applied 'no more stringently' to behavioral health than to medical or surgical benefits. The PID's March 2026 behavioral health parity enforcement focus produced directives in the Q1 2026 corrective action cycle on exactly this theory (Pennsylvania Insurance Department, Q1 2026, as cited in Pennsylvania Insurance Network Adequacy and Regulatory Enforcement 2026 [Internal project report], 2026).

The WellSpan/Penn State Health Tier Conflict

Highmark's 'my Direct Blue Lehigh Valley EPO' uses Penn State Health and WellSpan as network anchors. Simultaneously, Keystone Health Plan Central reclassified those same systems to Group 2 higher-cost status (Pennsylvania Insurance Department, 2025, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). The practical consequence: the plan offering the best physical access (Highmark's EPO) imposes the highest cost-sharing for the most locally accessible providers. Neither product independently satisfies the full adequacy spectrum. Consumers in RA6 face a structural choice between financially accessible and geographically accessible care — a choice that is itself evidence of

inadequate market design in the behavioral health dimension where 14.9% appointment rates confirm that financial accessibility and geographic accessibility are both simultaneously absent.

Statutory Enforcement Toolkit — This Rating Area

MHPAEA NQTL Complaint, 29 U.S.C. § 1185a — PRIMARY INSTRUMENT: File formal NQTL complaint with PID citing: (1) 14.9% BH appointment success rate vs. medical specialist rate [Mod. conf.]; (2) 33.2-day wait vs. 10-business-day federal standard; (3) 62.8% pediatric listing inaccuracy [Mod. conf.]. Carrier must show BH standards are no more stringent than medical. Failure → PID enforcement + federal DOL/CMS for self-funded plans.

45 C.F.R. § 156.230(a)(2) — Geographic Void Documentation: Contact every listed BH provider within 30 miles/30 minutes; document all failures. This creates the evidentiary record for both NQTL complaint and OON exception request under Act 146.

Act 146 OON Exception — Network Inadequacy: Proactive OON BH care due to hollow network: request Single Case Agreement; if denied, file Act 146 internal then external appeal. IDR (45 C.F.R. § 149.510) is NOT a consumer remedy.

42 U.S.C. § 300gg-115 (Directory Reliance): OON BH care from inaccurate directory listing showing provider as in-network: carrier must process at in-network rates. Directory reliance alone triggers the obligation.

RATING AREA 1 · NORTHWESTERN PENNSYLVANIA — ERIE HUB

Counties: Erie, Crawford, Mercer, Venango, Warren, Forest, and surrounding counties | Score: 14 | **Archetype C — Rural Structural Failure**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
3	3	3	2	3	14

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 13

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Highmark, Inc.	17.2%	**17.75%**	Together Blue; rural restructuring; HSA-compatible plans; CopayGo tiered; rural network nodes eliminated
UPMC Health Options, Inc.	11.7–16.3%	**20.18%**	Statewide including RA1; restrictive network; telehealth substitution for eliminated in-person access
Highmark Coverage Advantage	17.0%	**14.48%**	RA1/4; stable local network management; strict GLP-1 PA formulary

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 14

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Erie County (Erie Hub)	~37,000	~31,500	~5,500	**14.9%**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

Structural Erosion Through Telehealth Substitution

Rating Area 1's Archetype C classification at the boundary score of 14 correctly rejects what the enrollment data alone suggests: a 14.9% proportional decline lower than Philadelphia or

Allegheny does not indicate relative stability when the mechanism of access loss is examined rather than its rate. Highmark and UPMC's rural network restructuring has increased reliance on telehealth as a substitute for eliminated in-person capacity. This substitution reportedly carries a $31.85 per-telehealth-site fee (***Moderate confidence — reported in project compilations; verify against carrier Evidence of Coverage document or PID transparency filing***). For a rural household at the financial margin of a 102% net premium shock, a recurring utilization-contingent fee is a utilization deterrent that functionally mirrors the deductible deterrence effect driving the Bronze Migration.

The critical regulatory question the telehealth substitution raises: does telehealth access satisfy the 30-mile or 30-minute time-and-distance standard under 45 C.F.R. § 156.230(a)(2) as a categorical equivalent to in-person access? If carriers meet adequacy requirements by listing telehealth as the available in-network option within the required radius — rather than an in-person provider — the practical effect is adequacy compliance on paper while in-person access is structurally eliminated. This is a developing federal regulatory question whose resolution will materially affect whether RA1's network restructuring is compliant adequacy design or systematic circumvention of the radius requirement.

Duopoly Without Arbitrage

Rating Area 1 operates as a Highmark-UPMC functional duopoly. Unlike Rating Area 4 (Pittsburgh) where UHC's 12.6% provides a competitive floor, Rating Area 1 has no third carrier offering a materially lower rate. The consumer who finds both Highmark's 17.75% and UPMC's 20.18% unaffordable has no market-based alternative. This is why the Competition dimension scores 3 rather than 1 despite RA1's urban Erie County presence: two carriers without a competitive pricing floor is structurally equivalent to a monopoly for price-sensitive consumers at the margin.

Statutory Enforcement Toolkit — This Rating Area

42 U.S.C. § 300gg-115 (Directory Reliance) — PRIMARY CONSUMER REMEDY: OON care from inaccurate directory: carrier must process at in-network rates. NOT IDR (45 C.F.R. § 149.510) — IDR is provider-vs-plan arbitration only.

45 C.F.R. § 156.230(a)(2) — In-Person Access Challenge: Document in-person network failures within 30-mile/30-minute radius. Challenge telehealth as inadequate substitute for in-person specialist access; this is a developing compliance question.

Act 146 OON Exception: Proactive OON care due to hollow network: Single Case Agreement → Act 146 internal appeal → PID external review.

No Surprises Act / Act 252 of 2023: Telehealth site fees: if $31.85 fee [Mod. conf.] not disclosed before non-emergency care, Act 252 may bar billing beyond in-network cost-sharing.

PID Corrective Action Aggregation: Directory inaccuracy documentation beyond 90-day cycle under 42 U.S.C. § 300gg-115(a)(2) creates foundation for PID corrective action affecting all RA1 plan participants — highest-leverage advocacy investment in this market.

RATING AREA 9 · SOUTH CENTRAL RURAL PENNSYLVANIA

Counties: Fulton, Juniata, Huntingdon, Mifflin, Snyder, Union, and surrounding counties | Score: 16 | **Archetype C — Rural Structural Failure**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
3	4	3	2	4	16

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 15

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Capital Advantage Assurance	26.0%	**24.56%**	RA6/7/9; broad system access; deductible caps; hospital consolidation adjustment
Ambetter (Centene)	30.1%	**37.85%**	Statewide RA1-9; highest approved increase in Commonwealth; most restrictive HMO; near-universal GLP-1 PA; aggressive Bronze
Highmark, Inc.	17.2%	**17.75%**	RA9 coverage; rural restructuring; narrow EPO in rural pockets

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 16

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Juniata County	—	—	—	**~22.4% disenrollment; 485% net premium surge — highest in Commonwealth [Moderate confidence — modeled]**
Fulton County	—	—	—	**~19.8% disenrollment; 411% net premium surge; limited carrier choice [Moderate confidence — modeled]**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

Direct Causation: Act 54 Gap as Proximate Cause of Uninsured Status

The analytical distinction that makes Rating Area 9 structurally distinct from Rating Area 8 — where consumers also experienced significant premium shocks — is causation rather than magnitude. In Philadelphia, 14 competing carriers provide migration alternatives. In Fulton County, Pennie is documented in the source compilations as the only viable insurance mechanism for many residents (*The Rural Cliff* [Internal project report], 2026; ***Moderate confidence — modeled enrollment data***). For a household in the 151%–300% FPL band in Fulton County, Act 54 of 2024 (Pa. Laws, Fiscal Code, Budget Year 2024–25) was the only financial pathway to coverage. The program is unfunded. The household is uninsured. The causal chain has no intermediate links. This is not a contributing factor analysis — it is a direct causation claim supported by the structural absence of any market alternative.

The 485% net premium surge in Juniata County and 411% in Fulton County (both ***Moderate confidence — modeled Pennie estimates; verify against finalized PID rate records***) represent the combined force of Ambetter's 37.85% gross rate increase — highest in the Commonwealth — and the complete elimination of EPTC assistance. Ambetter operates statewide, but its pricing impact is catastrophic only where no alternative carrier creates a competitive floor. In Rating Area 9, there is no floor.

Why Market Mechanisms Cannot Substitute for Statutory Intervention

Rating Area 9 illustrates the meta-analysis's most important policy conclusion with maximum analytical clarity. In Archetype A markets, competitive mechanisms partially substitute for missing subsidies. In Rating Area 9, no substitution exists. Funding Act 54 in RA9 is not a supplementary instrument adding marginal benefit on top of existing market protection — it is the structural replacement for market protection that this market structurally cannot provide. The per-dollar return on Act 54 investment in RA9 is categorically higher than in RA8: in RA8, $1 of state subsidy partially duplicates competitive mechanisms that already exist; in RA9, $1 is the only dollar preventing a household in the 151%–300% FPL band from becoming uninsured.

Statutory Enforcement Toolkit — This Rating Area

42 U.S.C. § 300gg-115 (Directory Reliance) — PRIMARY CONSUMER REMEDY: OON care from inaccurate directory: carrier must process at in-network rates. Document the specific listing relied on, date accessed, and subsequent discovery of inaccuracy. NOT IDR (45 C.F.R. § 149.510).

Act 146 OON Exception: Proactive OON care due to hollow network: Single Case Agreement request → Act 146 internal appeal → PID external review (45-day max).

28 Pa. Code § 9.725 (Hold-Harmless): Foundational protection for any OON claim arising from RA9 network failure. Enrollee liability capped at in-network cost-sharing.

45 C.F.R. § 156.230(a)(2) — Geographic Void Documentation: Document distance to nearest actually available in-network provider. Exceeds 30 miles/30 minutes → carrier in direct statutory violation → foundation for both § 300gg-115 claim and Act 146 OON appeal.

Act 54 of 2024 Legislative Advocacy — STRUCTURAL REMEDY: No regulatory instrument substitutes for Act 54 funding in this market. Contact Pennsylvania General Assembly (legis.state.pa.us). Technical infrastructure is built and tested; legislative appropriation is the only required action.

RATING AREA 2 · NORTH CENTRAL RURAL PENNSYLVANIA

Counties: Elk, Cameron, Potter, Clinton, Lycoming, Sullivan, Tioga, and surrounding counties | Score: 19 | **Archetype C — Rural Structural Failure (Most Severe in Commonwealth)**

Table A

Stress Dimension Scores — At a Glance

D1: Competition	D2: Attrition	D3: Network	D4: Clinical	D5: Act 54	COMPOSITE
4	4	4	3	4	19

Note. Scores per criteria in Meta-Analysis Table 1. Scale 0 (lowest stress) to 4 (highest). All scores carry ±1 analyst uncertainty margin.

Table 17

Active Carriers, Approved Rate Changes, and Network Strategy, 2026

Carrier	Proposed	Approved	Network / Clinical Strategy
Geisinger Health Plan	14.1%	**11.59%**	RA2/3/5/6/7/9; deep clinical integration; expanded telehealth; integrated MA/Medicaid; Risant Health reorganization; $35 insulin/epinephrine cap
Highmark, Inc.	17.2%	**17.75%**	RA2 coverage; near-monopolistic in Elk/Cameron/Potter; BlueCard PPO essential for cross-border NY and southern PA access

Note. Approved rate changes: High confidence (PID 2026 rate filing summaries, as cited in 2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Strategy descriptions: Moderate confidence (secondary compilation).

Table 18

Enrollment Attrition by County/Hub, June 1, 2026

County/Hub	2025 Base	June 2026	Absolute Loss	Proportional Drop / Notes
Elk, Cameron, Potter Counties	—	—	—	**Highest proportional drops in these specific counties; near-monopoly with no arbitrage [Moderate confidence — modeled]**
Potter County (illustrative)	—	—	—	**45-yr-old, $47,000 income: lowest-cost Silver plan premium reportedly more than doubled [Moderate confidence — case study]**

Provisional. All enrollment figures are Moderate confidence — modeled estimates from Pennie data (as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). Verify against finalized Pennie enrollment records at pennie.com before regulatory use.

The Absent Corrective Mechanism: Why a Lower Rate Signals Greater Structural Risk

Rating Area 2's composite stress score of 19 — the highest in the Commonwealth — appears counterintuitive: Geisinger's 11.59% approved increase is among the lowest in the state. The analytical resolution is the meta-analysis's most important structural insight. In a functioning insurance market, competitive discipline bounds carrier rate increases: if one carrier prices aggressively, enrollees migrate to competitors. This competitive discipline is entirely absent in Rating Area 2. With Geisinger and Highmark as the only operating carriers in a near-monopoly (as cited in 2026 Pennsylvania Health Insurance Market Research Report [Internal project report], 2026), there is no market mechanism to constrain pricing, correct network failures, or improve directory accuracy. Geisinger's 11.59% is applied against a consumer population with nowhere else to go if the rate becomes unaffordable or if the network fails — which is structurally more dangerous than Ambetter's 37.85% applied in Philadelphia's 14-carrier market.

Ghost Networks as Geographic Voids, Not Consumer Inconvenience

According to the compilations, Texas A&M University researchers found 87% of Pennsylvania ACA marketplace provider listings contained at least one inaccuracy, persisting an average of 190 days (***both figures: Moderate confidence — Texas A&M University, as cited in The Mirage of Care [Internal project report], 2026; primary study not directly reviewed***). The 190-day persistence exceeds the 90-day verification mandate under 42 U.S.C. § 300gg-115(a)(2) by an average of 100 days. In Philadelphia, a directory inaccuracy means searching among 13 other carriers' listings. In Potter County, a directory inaccuracy for the only listed in-network specialist within 60 miles eliminates the category of care entirely for the duration of the inaccuracy's persistence. This is why the meta-analysis classifies this as a statutory violation trigger rather than an administrative error: a carrier that maintains a fictitious provider in a near-monopoly rural market has not committed an administrative oversight — it has falsely represented network adequacy in a geography where no competitive correction exists.

The Reinsurance Buffer: Necessary but Insufficient

Pennsylvania's 1332 reinsurance program provides a reported 4% premium reduction in Rating Area 2 (Pennsylvania Insurance Department, 2025, as cited in Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections [Internal project report], 2026). A 4% reduction against a 102% net premium spike is the arithmetic expression of the mismatch between the available policy instrument and the scale of the problem it addresses. The reinsurance mechanism suppresses gross premium increases at the carrier level — it does not restore affordability at the household level for the 151%–300% FPL cohort that has lost EPTC assistance entirely.

The PPO Necessity: A Structurally Imposed Premium Surcharge

Because restrictive HMO networks are operationally unworkable in Rating Area 2 — where the absence of local specialists makes HMO referral chains dysfunctional — many enrollees rely on Highmark's BlueCard PPO to access providers across the New York border or in southern Pennsylvania. These PPO products reportedly cost $200–$300 per month above HMO equivalents (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026; ***Moderate confidence***). For households already at the financial margin of the 2026 premium shock, this $200–$300 monthly surcharge is the cost of maintaining any meaningful care access in a geography where the HMO network lacks sufficient provider density to function. This represents a de facto geographic penalty built into the only practically viable coverage option in this rating area — a penalty with no equivalent in any urban market in Pennsylvania.

Statutory Enforcement Toolkit — This Rating Area

42 U.S.C. § 300gg-115(a)(2) — 90-Day Verification Mandate (ENFORCEMENT FOUNDATION): Document all directory inaccuracies with dates. Inaccuracy persisting across a 90-day cycle without correction = statutory violation. Creates foundation for: (1) individual directory-reliance claims; (2) PID corrective action affecting all RA2 plan participants — highest-leverage advocacy investment in this market.

42 U.S.C. § 300gg-115 (Directory Reliance — Consumer Remedy): OON care from inaccurate directory: carrier must process at in-network rates. NOT IDR (45 C.F.R. § 149.510) — IDR is provider-vs-plan only. Consumer does not need to prove network inadequacy — demonstrating directory reliance is sufficient.

45 C.F.R. § 156.230(a)(2) — Geographic Void Documentation: Systematically contact every listed in-network provider within 30 miles/30 minutes; document all failures. No actually available provider within radius = direct adequacy violation → foundation for Act 146 OON exception and PID enforcement referral.

MHPAEA NQTL, 29 U.S.C. § 1185a: 14.9% BH appointment rate [Mod. conf.] and 33.2-day waits [Mod. conf.] vs. medical access: file NQTL complaint with PID if BH materially more restricted than medical. Federal DOL jurisdiction for self-funded plans.

Act 146 OON Exception — External Review: Single Case Agreement → Act 146 internal appeal → PID external review (45-day max). Geographic void documentation is the evidentiary foundation.

Act 54 + 1332 Waiver Expansion (Policy — STRUCTURAL REMEDY): No regulatory instrument substitutes for structural policy intervention in RA2. Reinsurance buffer provides 4% [High conf.]; Act 54 at $50M authorized

level could provide 9–12% premium reduction for 151–300% FPL cohort [Moderate confidence]. Contact General Assembly: legis.state.pa.us.

Cross-Archetype Synthesis: What the Nine Areas Tell Us Together

Three findings emerge from the nine individual analyses that are visible only in aggregate.

First, the most predictive variable for consumer outcome in 2026 Pennsylvania is not the approved rate increase magnitude but the number of carriers available to absorb displaced enrollees. Ambetter's 37.85% increase in Rating Area 8 (14 carriers) produces plan migration. The same increase in Rating Area 9 (2–3 carriers) produces uninsured status. This asymmetry means that legislative interventions targeting rate increase magnitudes — such as enhanced PID rate review authority — will have asymmetrically higher impact in Archetype C markets than in Archetype A markets, and should be weighted accordingly in policy design.

Second, the NQTL framework under MHPAEA, 29 U.S.C. § 1185a, is the most underutilized high-leverage enforcement instrument across all three archetypes. Rating Area 6's Mental Health Desert provides the strongest single evidentiary case, but the same analytical framework applies in Rating Areas 1, 2, 4, and 9. No carrier in the Commonwealth has, to the knowledge of this secondary synthesis, successfully demonstrated full NQTL compliance by showing that behavioral health network adequacy standards are applied no more stringently than medical network adequacy standards. Systematic NQTL complaint filing — supported by the Texas A&M audit data as the quantitative benchmark at Moderate confidence — is the advocacy action most likely to produce systemic network redesign across multiple rating areas simultaneously, rather than individual claim resolution.

Third, Rating Areas 5 and 6 are the most policy-critical markets in the Commonwealth because their Archetype B* classification at composite score 13 means they are structurally one actuarial cycle from reclassifying as Archetype C. UPMC Health Plan's upward rate revision from 16.3% to 24.78% in Rating Area 5 is the operational definition of a market whose morbidity pool is deteriorating faster than its carrier's models projected. If that dynamic repeats in the 2027 rating cycle — healthy enrollees continue to exit, the risk pool continues to deteriorate, and the next

approved rate is revised further upward from an even higher proposed baseline — Rating Area 5 will meet every structural criterion for Archetype C. Preventing that reclassification is the actuarial case for funding Act 54 and expanding the 1332 waiver before the next open enrollment cycle begins. It is also the most efficient use of state resources: the cost of preventing Archetype C reclassification in Rating Area 5 is materially lower than the cost of managing an Archetype C market failure after it has occurred.

Primary Source Verification

Pennsylvania Insurance Department: 1-877-881-6388 · insurance.pa.gov
Pennie Exchange: 1-844-844-8040 · pennie.com
Federal CFR: ecfr.gov · PA Code: pacodeandbulletin.gov · PA Legislature: legis.state.pa.us
Pennsylvania Hospital Association: phalink.org

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